included in its registry. We assessed the INTERMACS (IMCS) classification in patients admitted in an ICU with cardiogenic shock.

Methods: Consecutive patients with cardiogenic shock on admission who were admitted in a tertiary hospital ICU. IMCS status was assessed at within the first 24 hours and 96 hours after admission. Outcomes (bi-ventricular assist device (BiVAD), heart transplantation (HT) and mortality) were recorded in hospital and at 3 and 12 months.

Results: The study included 87 patients (median age 60 [IQR:54-69] years). 41 (47%) patients had IABP and 27 (31%) were on mechanical ventilation. At 24 hours after admission, 7 patients (8.04%) with IMCS Profile 1 (critical cardiogenic shock), 18 (20.6%) with IMCS Profile 2 (sliding on inotropes) and 62 (71.3%) with IMCS Profile 3 (dependant on inotropes). Results are presented in the table.

Conclusion: In patients with cardiogenic shock, the INTERMACS classification is an easy way to classify patient's risk during the first 24 hours. Evolution of IMCS profiles allows to assess response to treatment over time. It may present as a useful tool in the ICU to discuss early the best strategies to manage cardiogenic shocks.

Table – Results

Best IMC	Profile within the first 24 hours IMCS (n=7)	Profile 1 IMCS (n=18)	Profile 2 IMCS (n=62)	Profile 3
Ischemic myocardiopathy	3(42.9%)	12(66.7%)	28(45.2%)	
Median age (yr.-IQ)	57(5.5)	62(16)	58(7)	
Evolution 24-96 hours: Died	5	4	1	
Evolution 24-96 hours: BiVAD pr HT	1	2	3	
Alive without BiVAD or HT at the 96th hour	1(14%)	12(66.6%)	58(93.5%)	
Evolution in ICU after the 96th hour				
Died		4	4	
BiVAD or HT		4	4	
Discharged from ICU without BiVAD or HT	1(14%)	4(22%)	47(75.8%)	
3-months mortality	n=5(71%)	n=12(67%)	n=21(34%)*	
1-year mortality	n=6(86%)	n=12(67%)	n=27(44%)*	

**p values <0.05 Profile 3 vs 2, Profile 3 vs 1*

368

Have the drug-related resuscitated sudden deaths disappeared?

Béatrice Brembilla-Perrot [Orateur], Jean-Marc Sellal, Pierre-Yves Zinzius, Jérôme Schwartz, Vladimir Manenti, Thibaud Vaugrenard, Daniel Beurrier, Hugues Blangy, Luc Freysz, Karim Djaballah, Nicolas Sadoul
CHU Brabois, Cardiologie, Vandoeuvre Les Nancy, France

The use of drugs is the subject of numerous recommendations. Most of sudden cardiac deaths (SD) are related to a ventricular fibrillation (VF) and ischemic heart disease, but some of them are drug-related. The purpose of study was to evaluate the prevalence of drug-related SD's and the possible changes during these past 20 years.

Methods: 239 patients, 181 men, 58 women, aged from 12 to 88 years (61±15) were admitted after SD resuscitation outside the acute phase of myocardial infarction, 139 before 2000 (group I), 100 between 2000 and 2010 (group II). Clinical data, treatment, electrolytes, echocardiography, Holter ECG, exercise testing, electrophysiological study (EPS), evaluation of coronary status and ergonovine test when coronary arteries were normal, were collected.

Results: The causes of resuscitated SD's did not change significantly during these 2 periods. The presence or not of heart disease (HD) did not differ: 34 group I patients (24%) and 34 group II patients (34%) had no apparent (HD)(NS). Ischemic HD, idiopathic dilated cardiomyopathy, valvular HD, coronary spasm, various HD's, preexcitation syndrome or ion channel disorders were as frequent in group I (42%, 11.5%, 12%, 3%, 3.5%, 4%) as in group II (34%, 11%, 6%, 4%, 6%, 5%). Drug-related SD's did not change during these periods: 38 patients presented a drug-related VT/VF or asystole with cardiac arrest, 20 (14%) before 2000 and 18 patients (18%) since 2000. SD was caused by hypokaliema or increase of QT interval or a major conduction disturbance. HD or abnormal ECG was present in 20 patients. Digoxin, diuretics, calcium inhibitors, betablockers, antiarrhythmic drugs alone or in association were the implicated drugs.

Conclusion: Drug-related arrhythmias continue to explain at least 15% of SD's. Despite the publication of numerous recommendations on the use of drugs, the number of fatal events that may be attributed to a cardiovascular drug did not decrease between the years before 2000 and after 2000.

369

Do we need to systematically hospitalize electrocuted patients in ICU?

Thibaut Petroni [Orateur] (1), Ghassan Moubarak (2), Olivier Varenne (3), Simon Weber (3), Denis Duboc (3)
(1) AP-HP, CHU Pitié-Salpêtrière, Institut de Cardiologie, Réanimation Médicale, Paris, France – (2) GH Paris Saint Joseph, Cardiologie, Paris, France – (3) AP-HP, CHU Cochin, Cardiologie, Paris, France

Introduction: An increased risk of malignant arrhythmias may exist following electrocution and electrocuted patients are routinely hospitalized in intensive care unit (ICU) for monitoring. The purpose of this study was to evaluate the short-term incidence of arrhythmias and sudden death in electrocuted patients.

Methods: This monocentric retrospective study included all patients hospitalized between January 2005 and November 2010 in ICU at Cochin hospital (Paris, France).

Results: We enrolled 31 consecutive patients (mean age 33±15 years, 74% men). Electrocution was due to domestic current (alternating current, 230V single-phase, 50Hz of frequency) in 65% of cases. Electrocution was a work related accident in 70% of cases. Superficial burns were observed in 87% of patients. Cardiac troponin Ic level (normal range <0.04 µg/ml) was found to be elevated in 16% of patients (mean 0,09±0,03 µg/ml) and creatinine kinase level was found to be increased in 55% of patients (426±713 UI/l). Electrocardiogram abnormalities were noticed in 84% of cases (ventricular hypertrophy in 11, incomplete bundle branch block in 9, diffuse ST-segment elevation in 6, and negative T waves in inferolateral leads in 13). Echocardiography was performed in 6% of patients and revealed mild septal hypertrophy (mean 13±2 mm) without segmental wall-motion abnormalities. During a mean ICU stay of 1±0.5 day, none of the patients presented atrial or ventricular arrythmias nor sudden death. During a mean follow-up of 30±10 months, 29% of patients were lost and the remaining 71% did not present physical or psychological sequelae related to electrocution.

Conclusion: In our study, the initial course of all electrocuted patients was uneventful. These results suggest that systematic hospitalization in ICU may not be mandatory after electrocution.

370

Characteristics and prognosis of patients treated by hypothermia for an out-of-hospital cardiac arrest related to a ventricular arrhythmia in a cardiac intensive care unit of a French Hospital

Caroline Vaillant (1), Guillaume Leurent [Orateur] (1), Frédéric Schnell (1), Dominique Boulmier (1), Isabelle Coudert (2), Hervé Le Breton (1), Philippe Mabo (1), Marc Bedossa (1)
(1) CHU Rennes, Cardiologie, Rennes, France – (2) SAMU, Rennes, France

Background: recent improvements in the management of out-of-hospital cardiac arrest (OHCA) should allow a better prognosis. This study aims at